

**DEPARTMENT OF SOCIAL & HEALTH SERVICES  
HEALTH & RECOVERY SERVICES ADMINISTRATION  
September 23, 2005**

**SeaTac Marriott  
3201 S. 176<sup>th</sup> Street  
Seattle, WA 98188**

**Members Attending**

Janet Varon  
Barbara Malich  
Maria Nardell  
Chris Jankowski, OD  
Claudia St. Clair  
Eleanor Owen  
Jerry Yorioka, MD  
David Gallaher  
Kathy Carson  
Elyse Chayet

**HRSA Staff**

Heidi Robbins-Brown  
Debbie Meyer  
Jim Stevenson  
Susan Lucas  
David Hanig

**Members Not Attending**

Blanche Jones  
Mark Secord  
Allena Barnes

**Guests**

Bob Perna  
Claudia Sanders  
David Gurule

**Approval of the Minutes and Agenda**

The minutes for the July 22, 2005, meeting were approved.

The agenda for today's meeting was approved as well.

**Community Reports**

**Barb Malich** – she asked about the impact of Medicaid revisions being discussed in Congress and by CMS.

Six community health center systems have joined together an electronic medical record project - all four Seattle Centers, Snohomish and Peninsula.

**Maria Nardella** – DOH /children with special health care needs. Staffing new taskforce on autism. Will be charged with making recommendations on services. Recommendations are due by Dec. 2006

**Bob Perna** – trying to get information out to practices about Medicare Part D. There is an abundance of information but it's hard to decipher it.

**Eleanor Owen** – Washington State was one of seven states to receive a federal transformation grant. This will be a great opportunity for the state to integrate services.

**Claudia Sanders** – Hospitals are following up on a legislatively-mandated study on the distribution of hospital payments around the state. Two studies are due. Navigant has been hired as the consultant.

WSHA has been working with Susan on the public hospital funding. CMS is looking to develop new rules and regulations.

Local health jurisdictions are working with HRSA on Medicaid administrative match questions. We're trying to get our first quarter payments prepared, but things are not matching up.

**Janet Varon** – She has been involved in efforts to partially restore the immigrant program. A lot of cooperative work has been accomplished. At the moment, 4,300 slots will open up in January 2006 for immigrant children. Everyone is anticipating that there will be more applications than slots available, with as many as 20,000 children eligible for this program. A waiting list will be started for those who don't get randomly picked for the initial slots.

**Barb Malich** - Finding orthopedic services in King County is a real problem. Barb said it also is a critical problem throughout the state.

A lot of training is planned as the prescription drug benefit for Medicare is implemented. On Nov. 8 (8:30 a.m. to 3:30 p.m.) in the Seattle Public Library, health workers will be on hand to discuss the program for people who want to know how to sign up.

### **2005-07 Budget Policy Implementation Matrix**

Janet suggested that members pick the top several issues. A number of these issues have already been discussed in community reports.

**Preferred Drugs --** Expansion of the prescription drug program should stay within the existing 6088 framework.

**Expand PRR program** – Janet expressed concern that people might be selected for PRR just on the basis of a spreadsheet, opening the door to selections that are made purely by the amount of prescription drugs a person takes regardless of why the drugs were prescribed. Janet asked how many more people would be put on this program. Also, who are the people being placed on this program? Are there access issues that come in to play.

Heidi noted, however, that selection for PRR is not just a numbers trigger. PRR looks extensively at client records and behaviors and consults with providers before selecting participants. Heidi suggested that the committee might want to invite Phyllis Coolen to a future meeting if they wanted to learn more about PRR and its policies

## **Medicare Part D Briefing**

We are in the last throes of pre-implementation. The plans go into effect on January 1, 2006. This will involve all Medicare clients, including the 100,000 that have dual eligibility.

The prescription drug plan organizations for our Region were announced this morning. David handed out the table listing the organizations. There will be 20 plans for most Medicare clients to choose from. Out of the 20 plans listed, there are four plans that will offer plans with premiums less than \$20 per month. These are the plans that Medicaid clients must choose between.

Our primary concern is the dual eligibles. They have extraordinary medical needs. There has been some changes in how CMS was going to manage the program. The dual-eligible clients will be auto-assigned into an initial drug plan. However, they can make changes and switch to other prescription drug plan any time that they want to.

What happens if someone doesn't pay their co-pays because of their limited income? It is our understanding that the prescription drug plans cannot "forgive" a client for failure to pay. However, pharmacies can still dispense drugs when customers can't pay the co-payment.

One potential problem for medical assistance clients is that the participating drug plans are free to send out marketing materials to all Medicare clients, including dual eligibles. That could lead Medicaid clients to think they can enroll in more expensive coverage than they can.

It also is our understanding that marketing materials will include an enrollment form – and that a great deal of this marketing information will inundate mailboxes of the Medicare beneficiaries.

WSMA is concerned about the questions that will be raised by the Medicare beneficiaries when they have a medical appointment. It would be great if we could prepare some local information that we could get out to practitioners.

WSHA has been working with WSMA on Part D. They had been thinking about doing medication reconciliation.

## **Children's Medical Caseload Evaluation**

David Mancuso presented Phase 2 of his survey work, analyzing why children's enrollment dipped in 2003 and 2004. The evaluation looked into the effects of all the policy changes in the children's medical caseload. (These are the children in households at or below 200% of FPL.) These policy changes mainly took effect in 2003.

The Phase 1 analysis showed increased exits were the most important source of caseload decline. The Phase 2 survey and case review focused on a sample of children who left the caseload and did not return to any DSHS medical coverage.

**We found that 40% of those who left were likely to be DSHS eligible.** The survey asked parents why did you leave Medicaid?

- 85% felt that DSHS made that decision for them.
- Only 15% stated that it was their decision.

**Some of the reasons given by parents as to why their child left Medicaid:**

- Didn't complete eligibility review
- Didn't verify income
- Reapplied, but never heard
- Too much "hassle"

**Another question asked was "do you plan to reapply for Medicaid?"**

- 88% said they were in the process of reapplying or would be reapplying.
- 8% said that they might be reapplying.

**Demographic comparisons of insured and uninsured "leavers."**

- At the time of the phone interview with parents 28% were not likely eligible for DSHS Medical and has other coverage;
- 32% would be DSHS eligible but have other coverage
- 36% would have maintained eligibility, but are currently uninsured.

**What did DSHS learn from Phase 2 of the survey?**

- Do they have non-DSHS coverage? Many do.
- If not, are they still eligible for DSHS health coverage? Most are
- Why did they leave? Most say DSHS made the decision
- To what degree were administrative issues a factor? Half cite admin.-related reasons
- Do they plan to return? Yes
- Do they differ from the kids who exited to other medical coverage? They are more likely to use the ER, less likely to have physician or clinic visits, and more likely to be Hispanic
- What might have been the consequences of maintaining a 12-month continuous eligibility policy?
- How many eligible children lost coverage and are uninsured? 36% of the "leavers"
- How many "ineligible" children might have continued in coverage for another 6 months? Up to 32% of leavers.

### **Planning for November Retreat**

Orientation around HRSA  
Committee's role  
Updates and input

### **Medical Necessity – Prior Approval Process**

The proposed rules are out for input, and the hearing for the rules is scheduled for next Tuesday, September 27.

The department will look at the recommendation of the doctor as well as the patient's medical history. After review, the department will assign a letter-grade value to the requested service:

**GRADE A:** A requested service will receive an "A" rating if there is a proven benefit. The proven benefit must be evidenced by strong support in the scientific literature and well-designed clinical trials. This would be approved

**GRADE B:** A requested service will receive a "B" rating if there is some proven benefit. This rating indicates that there is moderately good scientific data to support a requested services use in the cited applications. This would likely be approved.

**GRADE C:** A requested service will receive a "C" rating if it is investigational or experimental. This rating indicates that the data on this procedure is weak and inconclusive regarding safety and/or efficacy. This may be disapproved.

**GRADE D:** A requested service will receive a "D" rating if the service is investigational, experimental, ineffective, or unsafe. This rating indicates one of three conclusions: 1) the majority of the medical community does not support use; 2) the use of this service may have been shown to be unsafe or questionable as reported by current scientific literature, regulatory agencies, or by review of current State of Washington outcome data; or 3) there is little or no published evidence. This likely would be disapproved.